AN INQUIRY INTO THE RELATIVE MERITS OF

Vaginal Hysterectomy

AND HIGH AMPUTATION OR PARTIAL EXTIRPATION

BY

Galvano-Cautery

IN

CANCER OF THE CERVIX UTERI,

BY

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VAGINAL HYSTERECTOMY AND HIGH AMPUTATION, OR PARTIAL EXTIRPATION BY GALVANO-CAUTERY IN CANCER OF CERVIX UTERI. AN INQUIRY INTO THEIR RELATIVE MERITS.

BY JOHN BYRNE, M.D., M.R.C.S.E.

President's Address delivered at the Meeting of the American Gynæcological Society, held in Brooklyn, September, 1892. Published in compliance with the request of the American Gynæcological Society.

Fellows of the American Gynæcological Society:

It is fitting that I should embrace this first opportunity since our last meeting to thank you most heartily for the unsolicited honor which you have conferred upon me by electing me to preside over your deliberations. Indeed, I feel I would be wanting in a due appreciation of so high a mark of your esteem and confidence, if, while acknowledg-

ing my obligation, I failed also to solicit your aid and forbearance in the discharge of my responsible duties.

As I call to mind the first meeting of this society sixteen years ago, at which the loved and lamented Barker presided, and with that grace and intellectual elegance so characteristic of the man, of the distinguished and truly representative character of those who took a prominent part on that and subsequent occasions, and when I think of the chosen ones on whose shoulders from year to year the untarnished mantle of our first president has fallen, it surely becomes me, not only to express my thanks, but more particularly to crave your fraternal indulgence.

The pleasure of greeting the members of this society, need I say, is heartfelt, and yet, the gratification of welcoming to Brooklyn, for the first time, an association so distinguished is not without an alloy of regret as memory recalls the many absent ones; some in Europe ably representing the cause of American gynæcology at the Congress in Brussels; others detained by pressing professional duties; the declining health of one,[2] whose brilliant services in the past have shed lustre on our organization, and lastly that sorrow which the inevitable tribute exacted by death must always engender.

It is to be regretted that at this stage of our proceedings custom should have made it, in a measure, obligatory for me to trespass on your valuable time by any formal remarks, however brief. Because, when we consider the extent of our programme and the number and great practical value of papers to be read and discussed, it will readily be conceded that we have no right to waste time in the consideration of matters of more general interest. Besides it is of the first importance that distinguished Fellows, some of whom have traveled from distant States, and who have taken the trouble to formulate their views and thus further enrich the archives of our society, should have ample opportunity afforded them for profitable discussion and a free interchange of opinions. There is no way by which scientific material can be utilized to better advantage than by subjecting the product of individual brain and industry to intelligent, honest, and fearless criticism.

That this feature in our organization has been duly appreciated, and, as far as practicable, encouraged I believe, and yet its vast importance would seem to warrant the inquiry as to whether or not, by some modification of our rules, more time and a wider latitude should be allowed in our discussions, because the position of this society in the scientific world will depend not only on the character of its papers, but in no less a degree on the high tone

[2] Dr. Robert Battey.

and freedom of its discussions. I am fully alive to the necessity for fixed rules of debate in all well ordered societies, and in a scientific body like ours that their strict observance is essential to order and the expeditious disposal of the work mapped out in our programme; nevertheless, when we consider the peculiar nature of our organization, the representative character of its members, and the long interval between our meetings, it seems to me that no more than one-half of the time of each session should be devoted to the reading of papers ; that half an hour only should be allowed to each, and that the number of papers to be read at each session should be limited to three, or in all eighteen. This would allow ample but certainly not too much time for discussion, and as there is in our association a conspicuous absence of the redoubtable medical society orator, endowed with the peculiar faculty of employing words to supplant ideas, and who is always ready to advance a theory or a reason for everything, except perhaps as to how or why he himself should have earned celebrity or even recognition, there would, I imagine, be no danger that a little more liberty as regards time would be abused.

From these considerations I feel it incumbent upon me to occupy as little of your time as may seem to comport with my official duties and a due regard for the best interest of our society. After what manner I should proceed to obtain this most desirable end has been, I assure you, no easy matter for me to decide. To attempt an elaborate review of the rise and progress of gynæcology, though not without precedent, would, in my opinion, be an unpardonable infliction, and, considering the character of my audience, no less "stale, flat and unprofitable" than thread-bare subjects usually are. Quite as objectionable also and of questionable taste would it be to indulge in laudatory remarks on the work of this society and its widespread influence at home and abroad during the sixteen years of its existence. Its labors in behalf of suffering women, as exemplified in its published transactions, speak volumes, aye, sixteen times more convincing than the most elaborate eulogy. It is enough to say that from this source alone the student in gynæcology, (for we are all students), may glean the fruit of mature and well-digested experience.

Let this cursory reference to our good deeds suffice for the present. They have become the property of the entire professional world, and to that tribunal alone should we look for approbation.

My distinguished predecessor, Dr. Jackson, in his able address at our last meeting, took occasion to allude to certain abuses which had crept into the practice of gynæcology. One of these was the

alarming extent and frequency to which, through the beneficent but seductive agency of antiseptics, surgeons have been tempted to resort to dangerous and mutilating operations on the sexual organs of women.

This blot on our escutcheon I am happy to believe is rapidly becoming effaced, and I refer to it now merely to emphasize his forcible and timely warning. Such abuses, however much to be deplored, are in a measure inseparable from progress, and must be looked upon as the tribute of suffering humanity to science; strictly speaking they need but a passing comment, as they are sufficient for their own correction. Another equally deplorable cause of complaint was the subjecting of young and unmarried women to speculum examinations without due cause, and of which at least one disgraceful example was detailed. This is an abuse of so grave a nature and so pernicious in its tendency as to need no apology for again invoking your efforts toward its suppression. It will not suffice that we claim for ourselves and those in our special branch of medicine a comparative freedom from such abuses, and point to the cupidity of the general practitioner as a main source of the evil. It is our imperative duty as individuals, and certainly within the scope and province of societies like ours, to take cognizance of and to discountenance it. Instances have but too often come to my own knowledge, and must I fear be only too familiar to many here present, of moral and physical wrecks originating largely in this abominable practice. It is not too much to assert that very many of these deluded victims of a sacred confidence thus shamefully abused might have their modesty shielded and their infirmities cured by the aid of rational and judicious therapeutics, now, alas! so unpopular. Such, I assume, is the opinion of every experienced gynæcologist, and the remarks of our revered first president, in his address on "Medical Gynæcology" fifteen years ago, were doubtless prompted by his keen appreciation of these facts. His unassailable propositions touching meddlesome gynæcology were based on sound principles and supported by his own large and ripe experience. One declares that "*flexions in the virgin cause no symptoms except a slight dysmenorrhœa unless there be some vitiation of the general health, defective nutrition, neurotic disturbances or pathological changes other than the flexion.*" And again, "*all treatment, whether local, surgical, or mechanical, will fail in curing uterine disease so long as the blood is deficient in its proper proportion of nutritive elements, and therefore appropriate constitutional treatment is essential to success.*" The sound principles thus enunciated are as applicable to the practice of to-day as they were to that of the past,

and physiological laws, pathological researches, and moral ethics unite in demanding their observance by the specialist as well as by the general practitioner. Indeed, nothing less than the strongest presumption as to the existence of serious pelvic disease, and which judicious constitutional treatment has failed to relieve, can warrant speculum, or even digital, examinations in young and single women.

I trust I shall not appear as taking advantage of my position, or in any manner abusing the privileges due to your courtesy, if I ask your attention to a matter which, while it concerns a most important and, alas! too numerous a class, is one, also, in which I have a deep personal interest. It is a subject, moreover, regarding which the entire profession of medicine from the earliest period has taken a more than ordinary interest, and in its beneficent search after some means of relief for the afflicted has always, *until of late*, manifested the most liberal and humane spirit of inquiry. I refer to the surgical treatment of cancer of the uterus, and the prevailing disposition on the part of the more aggressive and radical members of our profession to disregard all means of relief save one, and that a dangerous, mutilating, and, as I hope to show, comparatively fruitless proceeding at best.

Some years ago there appeared in our midst a prominent advocate of hysterectomy fresh from his anti-uterine campaign of sixty-six hand-to-hand conflicts and eleven mortuary trophies. Thanks to the able, fearless, and timely protest of Dr. Jackson, who by his incontrovertible facts and sledge-hammer logic was the first to sound the alarm and plant the danger-signal, the great bulk of our brethren refused to be swayed by plausible arguments, or to accept conclusions which seemed to them wholly unwarranted and to say the least, premature. Some there were who, though willing to concede to hysterectomy a limited field—one strictly within pathological and rational bounds, yet skeptical as to the possible realization of hopes then indulged, were, nevertheless, not averse to testing, in suitable cases the heroic measures so forcibly advocated. There were not a few, however, who, probably finding the supply of removable ovaries and tubes becoming exhausted, and being unable to withstand the robust and persuasive eloquence of one who had just come fresh from the seat of war, determined forthwith to buckle on their armor and sally forth to do and to publish as many hysterectomies as they could find patients to submit to and live, but, *de mortuis nil*. By a few of the former class we have been favored with the net results of their careful, skilful and conscientious work,

and in some noteworthy instances it cannot be denied but that they fully sustain the conservative views of Dr. Jackson.

Thus, in the frank and unqualified statement of a leading member of this society, Dr. Reamy, regarding his experience in twelve cases, we have an example—but alas too rare!—of that scrupulous regard for the truth and the whole truth, which neither courts applause nor shrinks from criticism. Here we are told not only of the number who have escaped the more immediate dangers of the operation, but, what is of equal significance, the degree to which their periods of life expectancy have been curtailed through reckless surgery. Another equally conscientious and able Fellow[3] has not hesitated to proclaim, in the face of his well-known skill as an operator, four deaths out of sixteen cases.

In this connection, still another noteworthy example of the disposition on the part of some of our ablest Fellows to "render unto Cæsar the things that are Cæsar's," merits special mention and earnest commendation. I refer to a paper entitled "The Limits of Vaginal Hysterectomy for Cancer of the Uterus,"[4] being a clinical *résumé* of the work of two accomplished, expert, and painstaking operators, and every sentence of which bristles with startling facts and keen and unassailable logic. The author of this paper tells us that "the writer's purpose in presenting a paper which partakes of the character of a personal confession is simply to abjure an error into which he believes he has fallen, fortunately at the outset rather than at the end of his professional career." Who of us could have listened to or read this masterly and timely presentation of the subject, without a feeling of pride in the reflection that sentiments so free from the taint of personal gratification and so fearlessly uttered, should have emanated from and actuated one of our own Fellows. The result in nineteen cases may be summarized as follows:—Five (5) died from operation, and a sixth died on the fourth day from disease of the kidneys. Of the thirteen who escaped death, one had a recurrence within eighteen months, one in one year, two in seven months, one in six months, three in two months, one was well at the end of the eleventh month, one no report, and the remaining three (two of four months and one of three weeks) were too recent to report as to relapse.

I allude to the work of these operators as I might to that of many others both here and abroad, first, to emphasize the fact that though experience and skill are essential in hysterectomy, as in all grave surgical operations, they are not the only factors to be con-

[3] Dr Polk.

[4] H. C. Coe, *American Journal of Obstetrics*, 1890, pages 587–599.

sidered in determining or accounting for results, and, secondly, as a corollary, comparatively indifferent operators may have and as a matter of fact are constantly having "runs of luck" which, so far as regards cause and effect, may bear no logical relation whatever, either to the merits of the surgeon, the work performed, or even its advisability. As to why such experienced operators as Olshausen, Fritsch, Martin, Hoffmeir, Schroeder and Gusserow should have a primary mortality of from ten to twenty per cent., or an average for each of over fifteen, while Kaltenbach claims but two-and-a-half per cent., and Leopold only five, is a problem which I leave to others to solve or explain, for I cannot on any rational grounds, and I doubt very much if any of the gentlemen named put much faith in the operation of a special Providence.

The advocates of vaginal hysterectomy for cancer would, I presume, indignantly resent a charge so grave as that of misstating or misrepresenting facts, suppressing evidence which might conflict with preconceived notions, or attempting to belittle or ignore any rational measure for the alleviation of human suffering or the prolongation of life. Nevertheless, while advocating and practicing extreme surgical measures, to the defects of which they would seem to be invincibly blind, they persist in displaying an unworthy and unbecoming spirit of intolerance and a lofty contempt for their more conservative brethren, of whom it is not unusual for them to speak as being "behind the age." In no one direction has this unfair and illiberal spirit been so strikingly manifested as in the manner in which this radical element, both here and abroad, has disregarded a means of treating uterine cancer which, while it may be considered absolutely free from danger, has secured for the sufferer a period of exemption from relapse far beyond and in startling contrast to that of hysterectomy. In their struggle for pleas to justify hysterectomy they set up the operation of high amputation, as practiced by Schroeder and others, as the main target for their criticism. In this one particular at least, I have no disposition to take issue with them, because as between these two operations, whether as regards safety or utility, there is but little choice. Therefore, when an enthusiastic advocate of hysterectomy[5] declares that "to his mind there is absolutely no place for high amputation of the cervix in cancer of the womb;" and, moreover, "*as compared with vaginal hysterectomy, it is more difficult, more dangerous and more unreliable,*" I am almost inclined to agree with him, so far at least as regards its comparative worthlessness as a curative measure for

[5] Dr. Krug.

uterine cancer. And yet, if Landers' statistics of high amputation of the cervix performed in the ordinary way are to be relied upon, and twenty-seven out of a hundred-and-five patients so treated were living at the expiration of four years, criticism as to its utility comes with a very bad grace from the advocates of total ablation, as it much exceeds the best of their own records, as far as I have been able to discover. More than this, Winter says, that according to his observations after high amputation thirty-eight per cent. were well after two years, and twenty-six-and-a-half per cent. had no recurrence five years after operation. He also states that the mortality after high amputation at the Berlin Klinik (in 155 cases) previous to 1884 was but six-and-a-half per cent., against eight and nine per cent. obtained by combining the operations of Olshausen, Schauta, Fritsch, Kaltenbach, Leopold and Gusserow.[6]

He, Winter, also gives publicity to a most extraordinary statement attributed to Fritsch, to the effect that he (Fritsch) has noted thirty-six per cent. of *cures* at the end of five years after hysterectomy, and Hoffmeir, thirty-three per cent. at the end of four years.

When we come to examine the statistics in detail it will be found, I think, impossible to reconcile this statement with any data thus far obtainable.

Again, Dr. Coe quotes Hoffmeir as stating that he has performed fifty vaginal hysterectomies with six deaths, against thirty-three amputations with one death, and he affirms that the radical operation gives no better ultimate results.[7] It is well to remark in this connection that there is good reason to surmise that Hoffmeir's amputations were by the galvano-cautery loop, which was his method of operating previous to embarking in hysterectomy.

As to the published transactions of some of our societies, so prolific of daring exploits in pelvic surgery; the graphic descriptions of blood-curdling operations; the number of women, who, through the interposition of Divine Providence, are reported to have escaped death after hysterectomy and therefore "*cured*"; and the elaborate papers, loaded with bibliographical excerpts, usually exotic and supposed to signify deep research on the part of their authors; to see all this, I say, one would imagine that any proceeding short of complete pelvic evisceration had long since ceased to be worthy of the slightest consideration. In the most protracted discussions there is

[6] *Berlin. klin. Woch.*, 1891, No. 22. It will be noticed that the operations of Martin, Hofmeir, Schroeder and others are excluded from this estimate—unintentionally, of course.

[7] "The Limits of Vaginal Hysterectomy for Cancer of the Uterus," by H. C. Coe, M.D., *N. Y. Journ. of Obstet.* 1890, p. 597.

found to be a remarkable silence regarding any and every other means than one of combating uterine cancer, unless it be to condemn or ridicule, as stale and unfit pabulum for our modern gynæcological knights-errant. If, perchance, owing to exhausted material, or a desire on the part of some more conservative member to vary the sanguinary monotony of the proceedings, he should have the temerity to suggest partial ablation for uterine cancer, incredulity or cold indifference at once takes the place of enthusiasm and mutual admiration. He may be confronted with the gratuitous assertion that in their later campaigns, in figuring up the killed and maimed, the number of the former has been reduced to five per cent., with the hopeful prediction that it may become less in the future. Or, again, he may be met with some such extraordinary statement as that attributed to one of our own Fellows in discussing Dr. Janvrin's paper on hysterectomy, and which I hope is a misprint, namely, that "according to recent statistics, ten to fifteen per cent. remained free from a return of the disease eight or nine years after the operation."[8] Now, admitting that the usually ambiguous statistics of hysterectomy may be made wonderfully accommodating by a little effort, let me remark just here, and I speak whereof I know, that unless in a very few and exceptionally rare instances, and which being subject to the law of all rules, can have no logical application to the question involved, there is not to be found in the statistics of hysterectomy of any country or language, the slightest warrant for either statement. It is customary for gentlemen to supplement assertions like these by quoting the tables of Leopold or Kaltenbach, one with a primary mortality of three-and-a-half, and the other of five per cent. Such phenomenal results can have but little weight when contrasted with the experience of the host of equally able and expert operators, as Fritsch, Olshausen, Martin, Schroeder, Hoffmeir, Gusserow, and others. In fact they are but examples of happy coincidences and hair-breadth escapes, with which the history of medicine and surgery is so replete, and the same remark applies with still greater force to "runs of success" in the work of less pretentious exploiters, as when five, ten, or even twenty consecutive recoveries are reported and duly chronicled as "*cures.*"

Another advanced gynæcologist, and one withal for whom personally I entertain a high regard, in exhibiting one of the trophies of his skill a few months ago, said: "The patient had begun to bleed, and I found a little growth as large as a filbert, which I

[8] Dr. Geo. T. Harrison.

snipped off and examined. It proved to be malignant, and I removed the whole uterus. I have put myself on record in favor of the total removal of the uterus whenever cancer is discovered and proved to exist. When in 1885 this idea was expressed to me by Martin it seemed like a *shocking doctrine*, but when I saw these cases relapse after removal of the cervix alone, I decided always to cut as far from a cancer as possible."[9]

In the light of my own experience and with some knowledge of gynæcological history, *unwritten* as well as recorded, I must say it is hard to find words sufficiently expressive of my horror at the advocacy of this truly "shocking doctrine," and my unqualified disapproval of the fruits of its pernicious teaching. As to the cases known to "relapse after removal of the cervix alone," I have only to remark that such experience though sad, was no worse and no better than that of Schroeder and others, who still adhere to his methods, though as already remarked, an operation which, according to the statement of a pronounced advocate of hysterectomy, has afforded over two years to thirty-eight per cent. of cases operated upon, and five years to twenty-six-and-a-half per cent., should not be so summarily denounced. Moreover, gentlemen, they cannot possibly be ignorant as to the splendid results obtained by Dr. Baker through high amputation and subsequent cauterization. The truth is, the luckless subjects of amputation referred to, were, in all probability, denied the benefit of better treatment in obedience to the dictum of foreign authorities and obsolete methods. *Indeed, I cannot but feel that if, in the last decade particularly, these and all similarly afflicted women had been subjected to an operation whose greatest drawback would seem to be that it had been perfected, practiced and described nearer home, and for over twenty years, the results might have been different, and there would have been fewer pretexts for putting into practice any "shocking doctrine."*

In this connection may be noticed another specimen of "shocking doctrine," though really unworthy of serious comment. Some of our transatlantic masters not to be outdone in the advocacy of "shocking doctrines" have recommended, and, indeed, in quite a number of cases, resorted to the removal of a large portion of the pelvic basin, so as to attack the doomed uterus *a posteriori*. Who knows what the brilliant surgical engineer who originated this formidable method of attacking nature's heretofore impregnable defence, if still in the flesh, may next suggest—probably the removal of the pubic arch, preparatory to excision of the bladder for cancer

[9] Dr. E. W. Cushing in *Annals of Gynæcology*, vol. v., p. 553.

of that viscus. He might attempt to justify such a proceeding on the theory of the conservation, or rather transformation, of natural and providential resources. The ureters, for example, might be inserted into the rectum, and thus compensate for the loss of a disabled bladder by furnishing a perpetual enema. This would thoroughly annihilate constipation, so often a sore trial to defæcating humanity.

But let us now see what are the facts regarding the work at the Dresden Klinik, and of which we hear so much now-a-days.

Edward Leisse, (*Archiv. f. Gynæk.*, Berlin, 1891, xl., p. 261-65. Vaginal hysterectomy for cancer at Women's Klinik, Dresden,) says:

From October 11, 1883 to May 9, 1889, there were eighty cases, of which forty-five were living and thirty-five dead, or 43.75 per cent. Of the deaths directly due to the operation one was from sepsis; one was from peritonitis; one was from heart failure; one was from intestinal obstruction; a fifth was from exhaustion; one died from phthisis; two died from insanity. Noted as died, but neither date nor cause of death stated, twenty-seven. Total, 35.

Of the condition of the forty-five patients who were living at the date of report:

2	were free from recurrence after				7	years.
3	"	"	"	"	6	"
12	"	"	"	"	5	"
7	"	"	"	"	4	"
9	"	"	"	"	3	"
9	"	"	"	"	2	"
3	"	"	"	"	1	"
45						

In this table I notice that the word "died" appears twenty-eight times without any further explanation, and "no recurrence," or "well" forty-six times, which with the eight deaths above noted, brings the number up to eighty-two. However, as in the less complicated statistics of my own operations, I have discovered in simple addition an error of three, (but against me), I need say nothing.

It will be observed by this report that while death has been caused or hastened in a large number, 43.75 per cent., forty-five patients only out of eighty being alive at the expiration of two years, we have an *aggregate* exemption from recurrence of 168

years, or precisely three years, eight months and twenty-four days for each. I doubt very much if this brief period of exemption would greatly, if at all, exceed the duration of life in most cases of cancer of the uterus, if allowed to go untreated.

But, mark the extraordinary manner in which the compiler of these statistics sums up his tables:

He says of 80 cases operated upon

45 lived 2 years.
34 " 3 "
25 " 4 "
18 " 5 "
6 " 6 "
2 " 7 "

Thus presenting an array of figures so attractively linked together as to convey the idea that some large but indefinite number were made whole through the beneficent agency of hysterectomy.

Let us now see what Munchmeyer has to say regarding these same eighty cases, in his report of 1890. He had already reported forty-eight of the eighty cases, in the *Leipzig Journal*, vol. xxx, and states that six were "cured." [10] He now (1890) reports sixty-two more, making in all 110 cases of vaginal hysterectomy from October 11, 1883 to May 9, 1889. Eighty of these were for cancer, including two for sarcoma. Of the eighty, four died from the operation and seventy-six survived. Of the seventy-six, fourteen died later, leaving sixty-two. Of the fourteen deaths, ten were recurrences, one from consumption, two insanity, and one from heart failure. Of the sixty-two, three showed recurrence—probably rapid; of the forty-two (of his first series of forty-eight, *i.e.*, from October, 1883 to May, 1887, which he had previously reported as "cured,") the following summary is given:

1 was well after $5\frac{1}{2}$ years.
2 were well " $4\frac{1}{2}$ "
2 " " $4\frac{1}{4}$ "
3 " " $3\frac{3}{4}$ "
1 " " $3\frac{1}{2}$ "
6 " " $3\frac{1}{4}$ "
2 " " 3 "

[10] *Archiv f. Gynæk.*, Berlin, 1889, xxxvi., pp. 424–459. Also, Verhaud *Deutsche Gesel. f. Gynæk.*, 1890, pp. 298–310.

3	were well after		$2\frac{3}{4}$	years.
2	"	"	$2\frac{1}{2}$	"
2	"	"	$2\frac{1}{4}$	"
3	"	"	2	"
3	"	"	$1\frac{1}{2}$	"
3	"	"	$1\frac{1}{4}$	"
4	"	"	$1\frac{1}{4}$	"
37				

"Therefore," he says, "forty-two lived longer than two years, and of these, twenty-seven were free from recurrence."

Now, inasmuch as the list falls short by five cases, and ten have had an exemption of but little over one year, it is past my comprehension to understand how forty-two could have been cured more than two years.

This, however, is but one of the many mysterious features of statistical construction. To sum up:

Munchmeyer says there were twelve patients who were free from recurrence after three years.

Leisse says there were only nine.

Munchmeyer says there were but four from four-and-a-quarter to four-and-a-half years.

Leisse says there were seven over four years.

Munchmeyer says there was but one after five years.

Leisse says there were no less than twelve.

Munchmeyer records none after five-and-a-half years.

Leisse says there were three.

Of the second series of thirty-eight cases operated upon from May 24, 1887 to May 9, 1889, all comparatively recent, he reports two primary deaths and one recurrence at one month; one at three months; one at eight months; one at nine months; two at twenty-one months; one "tolerably well." In all nine; twenty-seven being noted as recovered from the operation.

Some of the "cured" cases may possibly be included in Leisse's list between October 11, 1883 and May 10, 1885, as six of the ten cases operated upon during that period are noted by Leisse to have had no relapse for five years, eleven months and fifteen days, to seven years, three months and sixteen days. Thus thirty-seven patients out of eighty operated upon had an aggregate period of exemption from recurrence of one hundred years and three months, which gives to each an average of two years, eight months and fifteen days.

It cannot be denied but by reason of more mature experience and improved methods regarding the technique of hysterectomy, the primary mortality has been much reduced within the past four or five years, and that the statistics of Dr. Sarah Post, showing a mortality of twenty-four per cent., apply more particularly to a period anterior to 1888. And yet, if perfection in the technique of any operation cannot be attained after so many trials, of what practical value I would ask, are all these clinical efforts?

Let us then see how the case stands at the latest date. But, before proceeding further, I beg to call your attention to some of the many examples to be found of the manner in which the statistics of hysterectomy are being constantly distorted and misrepresented to suit the whims and prejudices of writers. Thus, a gentleman we all know and respect says:[11] "I am thoroughly convinced that the removal of the uterus per vaginam for cancer far surpasses in its *remote* or *permanent success* not only all other operations for cancer of the womb, but also all operations for cancer in other parts of the body." This opinion is substantiated by the remarkable statistics of the Dresden Klinik. And how think you that he summarizes these said statistics? He says: "The following are the facts; of eighty patients examined over two years after the operation, forty-five were free from recurrence; 58.6 per cent. (of fifty-eight patients examined) were well after three years; 59.5 per cent. (of forty-two) after four years; 60 per cent. (of thirty) after five years; 66.6 per cent. (of nine) after six years; and the two patients that had survived the operation for seven years were perfectly well." This is another example of the many and marvellous statistical contortions which it is found expedient to offer in lieu of plain and intelligible "*facts.*"

In this connection also, it is impossible to overlook the remarkable statement of authors who in one page "*favor the removal of the entire organ by the vagina, even in cases of cancerous disease of the cervix alone, rather than take the chances of a high amputation of the cervix, when possibly the disease has already extended beyond the internal os,*" and in the very next approve of amputation, *provided the operator's line of incision has gone through entirely healthy tissues, when he should reasonably expect to have effected a permanent cure.*"[12]

In this, one of the very latest and not least pretentious works on the diseases of women, we find Leopold's table of eighty hyster-

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[11] Dr. Goodell in *Med. News*, Dec. 5, 1891, p. 641.

[12] Thomas and Mundé, "Diseases of Women." p. 588–89.

ectomies, of which four died from the operation, ten from quick relapse, and four from other causes, leaving sixty-two to be accounted for, thus analyzed and authoritatively disposed of, for the edification and guidance of its readers: "*Of the sixty-two still surviving three only have been attacked by a recurrence; the others are "cured;" the time since the operation varying from five-and-a-half years to one year and three months.*" Thus fifty-nine are supposed to be accounted for, and yet he says:

"*Of seventy-six patients remaining under observation after recovery, there were free from recurrence*:

At $5\frac{1}{2}$	years	3	At $2\frac{1}{2}$	years	2
$4\frac{1}{4}$	"	2	$2\frac{1}{4}$	"	2
$3\frac{3}{4}$	"	3	2	"	3
$3\frac{1}{2}$	"	1	$1\frac{1}{2}$	"	3
$3\frac{1}{4}$	"	6	$1\frac{1}{4}$	"	3
3	"	2	Below $1\frac{1}{4}$	"	4
$2\frac{3}{4}$	"	3			

In all thirty-seven cases, the trifling number of twenty-two not being worthy of consideration!! Finally, and as if to emphasize his admiration for results so phenomenal, that "*one cannot ask for much better,*" he winds up this extraordinary feat in arithmetic by informing his readers that "*it will thus be seen that seventy-two of these seventy-six cases were still well without recurrence of the disease from one to five-and-a-half years after the operation!!*"

Elsewhere, in quoting Ott approvingly, with thirty operations and no deaths, Péan is also credited with twenty-five operations and no deaths; whereas, though I am not prepared to question the accuracy of Ott's tables, the truth is, Péan [13] has been charged with seven deaths in thirty-eight operations. So if the above statement be true, he must have had seven deaths in his later thirteen operations, of which, however, I have not been able to find any record.

Now what does the report of Ott show? Of the thirty cases tabulated, thirteen are recorded "uncertain."

Of non-recurrences one has had no recurrence for two years and two months; one for two years and one month; two for one year and one month; four for one year.

Of recurrences, one relapsed at thirteen months: one at eleven months; one at ten months; one at nine months; one at five months; two at three months; two at one month. Total nine.

So out of the entire thirty successful (?) operations two only are reported to have escaped death or recurrence for over two years,

[13] Binne, *Weekly Med. Review*, St. Louis, xxiv, 1891, p. 201–4.

while each of the seventeen cases accounted for has been blest with an average period of exemption from recurrence of eight months and fourteen days. Would it not occur to anyone of ordinary observation or experience that these patients might and doubtless would have lived much longer and suffered much less if their earthly career had ended before the advent of advanced gynæcology? Is it not an insult to the intelligence of the profession to be told by anyone aspiring to authorship that reckless clinical work like this should be commended or accepted as proof of the blessings in store for suffering women through the beneficent agency of hysterectomy?

Before proceeding further, let me call your attention to that other and safer method of treating uterine cancer, to which I have alluded—

GALVANO-CAUTERY.

During a quarter of a century or more following the introduction of electro-cauterization by Middledorpf, of Breslau, though the practice was then attended with much difficulty, owing to imperfect apparatus, yet its peculiar advantages over destructive chemical agents in the treatment of uterine cancer had been repeatedly demonstrated. Indeed, it may be said that up to 1880, or thereabouts, the choice of proceeding lay between this and high amputation of the cervix by scalpel or scissors, as practiced by Schroeder, and adopted by others even to the present day. This latter surgical measure having soon fallen into merited disrepute, and the difficulties at first found to attend the practice of electro-cautery not yet having been overcome, the time seemed ripe for the introduction and advocacy of the more unsparing and admittedly more dangerous operation of total extirpation of the uterus. It may be well here to note that during all this time, *i.e.*, since the introduction of galvano-cautery, and even up to the present day, while the number of those who have given this last-named method a fair and practical trial may be enumerated on one's fingers, the more aggressively radical and too often inexperienced candidates for surgical notoriety, who during the last decade seem to have laid siege not only to the uterus but to the whole sexual apparatus, may be counted by the hundred.

Some years ago gynæcologists in New York and elsewhere attempted this method of operating in a limited number of cases, but they, like some modern authors who ought to know better, labored under the delusion that the entire practice of galvano-cautery consisted in looping a cervix, recently styled "linear amputation," or

removing pedunculated tumors. In their clumsy and often abortive attempts to operate, they soon discovered that a galvanic battery did not possess the automatic qualities of a Swiss music-box; that the adaptation of this agent to the requirements of pelvic surgery demanded, in addition to operative dexterity, some patience and a very moderate but easily acquired knowledge of a subject not to be found in medical text-books. As this naturally involved some expenditure of time, money and grey matter, another discovery was not slow to be reached, though it has been kept a profound secret until lately. In fact it is nothing more nor less than that the galvanic cautery is only applicable "*where the disease is of the cauliflower variety and entirely limited to the intra-vaginal portion of the cervix.*"[14] As has been so often remarked regarding other great discoveries and inventions of subtle minds, one cannot help wondering how, and for so many years too, this valuable piece of information could have escaped the notice of such able workers in this field, as Hoffmeir, Powlack, Noeggerath, and others. But this is not all, for the writer referred to, probably fearing that he may have conceded too much, gravely informs us that "it has seemed to us that the stimulant action of heat tended at times to increase the rapidity of growths of the malignant disease."[15]

> "Now in the names of all the gods at once,
> Upon what meat doth this our Cæsar feed
> That he hath grown so great?"

It is safe to say, therefore, as I have stated repeatedly during the past twenty years, that as amputation of the cervix, high or low, is worse than useless without cauterization, and further, that it is an operation by no means free from danger, there are but two surgical measures worthy of mention to choose between at the present day. These are (1) high amputation, or excision, as the case may be, by *galvano-cautery*, not only of all diseased parts, but as much more and beyond the supposed danger-line as can be safely taken away, the same to be followed by a thorough *dry-roasting* of all exposed surfaces; or (2) vaginal hysterectomy, with its more attractive surgical glamour and ghastly record of lives shortened and often sacrificed on the altar of what is now-a-days mis-called "progressive gynæcology."

As to the electric cautery, though its claims to recognition are based on no inconsiderable number of carefully observed and duly recorded facts, covering a period of a quarter of a century, and to be found in the periodical literature of every civilized country, yet,

[14] Thomas and Mundé, p. 581.

[15] Ibid. p. 594.

strange as it may appear, comparatively few gynæcologists, in this country especially, have taken the trouble to know anything whatever about it practically, and fewer still have conducted such operations in a proper manner, or to an extent sufficient to warrant any opinion as to its real merits. Thus, I have known an instance of a patient having been operated upon before a class of students, in the following manner (not in Brooklyn, however): the vaginal portion of the cervix having been removed by the cautery loop, the uterine cavity was then curetted, but in so rough a manner as to induce copious hæmorrhage; the bleeding parts were then subjected to a stewing process by a thermo-cautery, a tampon applied, and the patient soon after transferred in a carriage a considerable distance to a hotel. Need it be wondered at that she died from hæmorrhage within twenty-four hours. This is but one of many equally inexcusable and criminal blunders which have come to my knowledge from time to time, and thus between the arrogance and skepticism of those who are ever ready to condemn what they have never even tried to understand, and the opposition of others who have demonstrated their own incapacity, galvano-cautery may be said to have had a hard fight for recognition.

As one who has earned the right to speak I claim for this method of treating uterine cancer two most important advantages: (1) absolute freedom from danger, immediate or remote, and (2) a longer respite from recurrence of the disease than has yet been shown by the most favorable and ingeniously constructed statistics of hysterectomy. *For example, in nearly four hundred cases not a single death due to the operation; in forty out of sixty-three cases of cancer of the portio vaginalis, twenty-three having strayed away, periods of exemption ranging from two to twenty-two years, being an average for each one of over nine years. Of eighty-one cases involving the entire cervix, —thirty-one were lost sight of, ten relapsed within two years, five had no recurrence for two years, eleven for three years, six for four years, eight for five years, six for seven years, two for eleven years, one for thirteen years, and one for seventeen years. So of forty of this class whose histories could be followed up, there was an average period of exemption for each of nearly six years.* And yet, these figures are not up to date by any means, because, many of the patients of this class, five at least to my personal knowledge, and now residing in this city, are entitled to an additional credit of three to four years.[16]

[16] "A Digest of Twenty Years Experience in the Treatment of Uterine Cancer by Galvano-Cautery," by John Byrne, M.D., *Trans. Amer. Gynæcological Soc.*, vol. xiv., p. 91.

Let us disregard for the present the benefits proved to have been derived from galvano-cautery in those desperate and utterly hopeless cases of extensive cancerous destruction of the uterus, which even a hysterectomist would abandon, and which constitute the vast majority of all cases brought to our notice. With regard to the question of primary danger attending hysterectomy it would be irrelevant folly to quote either the history or the statistics of ovariotomy in support of the former. There is no comparison between the two operations, especially as regards that which should be the main object of all surgical procedures, namely, a more or less complete restoration to health, or, at the very least, a prolongation of life commensurate with the risk involved.

The only question then worthy of serious consideration in this very serious business, so far at least as the ill-fated victims of cancer are concerned, is as to which of the two operations, vaginal hysterectomy, or that of which the above epitomized record speaks, can be said to hold out to the afflicted the greater benefits, immediate and prospective.

So far as the question of primary mortality is concerned, we will find on further statistical research, that the tables of the Dresden Klinik, the glory and boast of our radical brethren, present in this one respect a phenomenal experience merely, and, consequently, to accept such results as a basis for generalization would be "a mockery, a delusion, and a snare." But were it otherwise, and if the success of every hysterectomist, past, present and to come, equalled that of Kaltenbach or Leopold, there would still remain to be seriously considered, and if possible settled, other questions of far-reaching import, namely: (1) Has vaginal hysterectomy for uterine cancer conferred upon the unhappy victims of this disease a sufficiently long respite from relapse to entitle it to a place in the list of justifiable operations? (2) In a large proportion of all cases thus far exposed to vaginal hysterectomy, has not suffering been increased and life greatly shortened through its agency? And (3) may not the relatively small proportion of prolonged non-recurrences be reasonably accounted for by possible errors in diagnosis, or what might be termed a *cacoethes operandi*, which could not resist the extirpation of an entire uterus though it should have but "*a little growth on the cervix the size of a filbert.*"

I repeat, my friends, these are questions which we are morally, and in the interest of humanity as well as true progress, bound to consider seriously and carefully, and with that view I would ask your attention to some further statistics.

Prof. Pozzi[17], an able, consistent, and yet impartial advocate of this and other radical measures, gives the following table touching mortality from hysterectomy previous to 1890:

Fritsch,	60 operations,	7 deaths.
Leopold,	42 "	4 "
Olshausen,	47 "	12 "
Schroeder and Hoffmeir,	74 "	12 "
Staude,	22 "	1 "
A. Martin,	66 "	11 "
	311	47 or about 15 per cent.

E. Boerner (Graz) *Wien. klin. Woch.* 1889, ii. page 272–4, quotes:—

Martin,	66 operations,	11 deaths.
Fritsch,	63 "	7 "
Schroeder,	60 "	12 "
Leopold,	44 "	3 "
Hoffmeir,	42 "	4 "
	275	37 or about 13½ per cent.

Martin in combining operations of Fritsch, Leopold, Olshausen, Schroeder, Hoffmeir, Staude and his own, gives a mortality of fifteen per cent. And with regard to recurrences Martin has stated that out of 214 women operated upon *successfully* by Leopold, Schroeder, Fritsch and himself, only five were living at the end of four years.[18]

Gusserow[19] reports sixty-seven operations from 1883 to 1891, sixty-four by himself and three in his absence—seven deaths from operation; ten of the operations having been done within six months he considered too recent for argument, but well at time of report. Of the remaining fifty, sixteen are living, twelve are dead of recurrence—one at three years, four from one year to eighteen months, and seven from four to seven months. Of the sixteen living:—

1 well, 8 years		after operation.
1 " 4½ "		" "
1 " 3 " 2 mos.		" "

[17] Pozzi, Paris Edition, 1890, p. 405.

[18] Dr Coe.

[19] *Berlin. klin. Woch.*, 1891, xxvii. also in *Centralb. f. Aertz. Œst. Ungarn.* 1891, vol. i., p. 207.

1 well, 3 years after operation. Deaths, 11 per cent.
5 " 2 " to 27 mos. " "
6 " 1 " " 19 " " "
1 " 8 mos. " "

Average respite to each of the sixteen, less than two years; and three only have reached a period over three years without recurrence.

S. S. Zayaitzki, *Med. Oboz.*, Moscow, 1890, xxxiv., p. 381 to 427, reports sixty-five hysterectomies from June 22, 1883 to February 15, 1890, with nineteen deaths from the operation or nearly thirty per cent., but gives no particulars except in the first seventeen cases, *i.e.*, June 22, 1883 to Dec. 1, 1885. Of these seventeen operations there were seven deaths from operation, five were lost sight of, and as to the other five:—

1 had no relapse for 7 years.
1 " " " " 5 " and 7 months.
1 " " " " 1 year.
1 " " " " 4 months.
1 " " " " "a few months."

As to the forty-eight operations between February 7, 1886, and February 15, 1890, nothing is stated regarding recurrence, except that it was "rapid" in four cases, and but two primary deaths are admitted, one from peritonitis, and one from heart-failure[20], though elsewhere he acknowledges, as above stated, no less than nineteen deaths from the operation or a primary mortality of thirty per cent. In forty-two noted as "recovered," we are left to conclude that these patients survived the operation and its immediate consequences. However this may be, if the history of these forty-two cases should have turned out to be anything like that of the first seventeen, such experience could hardly be advanced as an argument in favor of hysterectomy for uterine cancer.

ROSSIER'S REPORT.[21]

Of twenty-five cases from June 30, 1887, to December 29, 1891.

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[20] Zayaitzki, *Med. Oboz.*, Moscow 1890, xxxiv., p. 381–427. Note the inconsistency, thus: If seven died in the first seventeen operations and there were nineteen deaths in all there must have been twelve primary deaths in these forty-eight cases.

[21] G. Rossier *Correspbl. Schweiz Aerzt.*, 1892, xxii., p. 202–212. Woman's Klinik, Basel.

2	relapsed	within	15	months.
6	"	"	11	"
1	"	"	6	"
1	"	"	5	"
2	"	"	4	"
12				

Hoche's[22] table of 150 hysterectomies refers to relapses as follows:—

At the end of three months five were lost to sight, twenty-three had relapsed, and 122 had shown no symptoms of relapse.

At the end of				6 mos.		6	lost sight of,			20	relapsed or dead			96	no relapse				
"	"	"	"	9	"	5	"	"	"	10	"	"	"	81	"	"			
"	"	"	"	12	"	2	"	"	"	9	"	"	"	70	"	"			
"	"	"	"	18	"	10	"	"	"	8	"	"	"	52	"	"			
"	"	"	"	2 yrs.		14	"	"	"	0	"	"	"	38	"	"			
"	"	"	"	3	"	21	"	"	"	0	"	"	"	17	"	"			
"	"	"	"	4	"	10	"	"	"	1	"	"	"	6	"	"			

Thus at the end of eighteen months, seventy or about forty-seven per cent. of the whole were known to have relapsed, and at the expiration of four years there remained, so far as is known, but six without relapse or four per cent. of the whole!

N. Flaischlen,[23] reports twenty hysterectomies; thirteen of which were by Paul Ruge, between December 6, 1884 and March 6, 1890, with three deaths, or fifteen per cent.

Phenomenof, Vrach, St. Petersburg, 1890, xi., p. 1015, 1049 and 1072, records twenty-three operations from January 1886 to May 1890 with three deaths, or thirteen per cent.

L. C. Richelot, *Bull. Med. Chir. Soc.* Paris 1891, xvii, p. 617, in a discussion on vaginal hysterectomy, quotes eighty-six operations by eight operators, with twenty-nine deaths, as follows:

Kirmasson	3	operations,	2	deaths.
Polaillon	6	"	2	"

[22] Pozzi, p. 408.

[23] *Deutsch. med. Woch.*, 1890, xvi. p. 632, July, 1890.

Marchand	7 operations,		4 deaths.	
Monod	2	"	2	"
Berger	2	"	2	"
Bouilly	21	"	4	"
Richelot	24	"	9	"
Terrier	21	"	4	"
	86		29	or 33.7 per cent.

Paul Ségond, page 688 as above, reported thirty-three hysterectomies and seven deaths, or over twenty-one per cent. Terrier thirty four hysterectomies and eight deaths, or over twenty-three per cent.

Krukenberg[24] reports 235 vaginal hysterectomies by various operators from May 1, 1880 to April, 1891, of which he tabulates 130 as follows, viz.: in 102 the operation was for cancer of the cervix, and in twenty-eight the fundus was the seat of the disease. Of the first, sixty-three had no recurrence for periods ranging from two to eight years, and in thirty-nine recurrence took place in from one to two years; one died from pneumonia, and two operated upon in April, 1891 are noted as recovered. In this report 105 cases are not accounted for, and it is to be presumed that these represent deaths from the operation and quick relapses.

Moreover, this table being made up of a few selected cases from the record of each of a number of leading operators can hardly be accepted as a safe basis for generalizing as to the period of exemption obtainable by vaginal hysterectomy. For instance, the sixty-three operations selected by Krukenberg out of 130 consisted of twenty-three by Olshausen, eleven by Hoffmeir, ten by Thorn, six by Schroeder, six by Winter, four by Kramer, one by Cohn, one by Bencheiser, and one by Reichel; in all sixty-three.

Of the twenty-eight cases operated upon for cancer of the fundus, no less than seven died the first year from recurrence, but strange to say, not a single primary death is recorded, the table being constructed apparently to show periods of exemption only. The period covered for these twenty-eight cases was from December 1885 to April, 1891.

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[24] *Zeitsch. f. Geburts. und Gynæk*,, 1892, xxiii., p. 94–158. University Woman's Klin., Berlin.

OLSHAUSEN'S NON-RECURRENCES.

DATE OPERATION.	DATE OF REPORT.	RESPITE.	REMARKS.
May 11, 1887.	Aug. 1, 1891.	4 yrs. 3 mos.	Cancer of vertebra.
" " "	Oct. 21, "	4 " 5 "	
June 8, "	June "	4 "	
" 15, "	May 6, 1890.	2 " 11 mos.	Recurrence in scar.
" 22, "	July 29, 1891.	4 " 1 "	
" 13, "	" 20, "	4 " 1 "	
July 25, "	" 9, "	4 "	
Aug. 6, "	" 28, "	4 "	
Sept. 15, "	" 7, "	3 " 10 mos.	
Nov. 23, "	" 9, "	3 " 8 "	
Dec. 2, "	" 7, "	3 " 6 "	
Jan. 12, 1888.	" 27, "	3 " 6 "	
Feb. 14, "	" 7, "	3 " 3 "	
May 7, "	June 29, "	3 "	
" 30, "	July 28, "	3 " 2 "	
" 30, "	Aug. 25, "	3 " 2 "	
Nov. 5, "	July 11, "	2 " 8 "	
Dec. 20, "	June 5, 1890.	1 " 6 "	
Jan. 10, 1889.	July 21, 1891.	2 " 6 "	
Feb. 4, "	" 7, "	2 " 5 "	
" 5, "	May 22, 1890.	1 " 3 "	
March 12, "	June 22, 1891.	2 " 3 "	
July 19, "	July 25, "	2 "	

Seven over four years; eight over three years ; six over 2 years ; two over one year. Total twenty-three.

HOFFMEIR'S CASES.

DATE OPERATION.	DATE OF REPORT.	EXEMPTION.	
1. Apl. 8, 1883.	Oct. 1888.	4 yrs. rec.	Died 5th year—
2. June 24, "	June 1891.	8 "	Recurrence.
3. Sept. 19, 1885.	" "	6 "	
4. Apl. 10, 1886.	July 20, "	5 "	
5. Aug. 9, "	" 20, "	5 "	
6. " 16, "	Aug. 15, "	5 "	
7. Feby. 3, 1887.	June "	4 "	
8. " 13, "	" "	4 "	
9. Apl. 6, "	March 4, "	3 "	Died of recurrence.
10. " 16, "	June "	4 "	
11. " 20, "	" "	4 "	

One over eight years; one over six years; three over five years; five over four years; one over three years. Total, eleven.

THORN'S CASES.

DATE OPERATION.	DATE OF REPORT.	EXEMPTION.
1. June 24, 1887.	July 5, 1889.	8 years
2. " 11, "	" 2, 1891.	4 "
3. " 21, "	Apl. 25, "	4 "
4. Aug. 24, "	Aug. 7, "	4 "
5. Oct. 20, "	" 14, "	3 " 9 mos.
6. " 3, "	July 9, "	3 " 9 "
7. Nov. 17, "	" 30, "	3 " 8 "
8. Dec. 29, "	" 11, "	3 " 8 "
9. Jany. 20, "	Aug. 10, "	2 " 6 " [25]
10. " 23, "	July 8, "	3 " 6 "

Three over four years; five over three years; two over two years. Total, ten.

SCHROEDER'S CASES.

DATE OPERATION.	DATE OF REPORT.	EXEMPTION.
1. May 1880.	May 1884.	4 years. Died of Apoplexy.
2. Jany. 1881.	Feby. 5, 1884.	3 "
3. Dec. 1883.	Dec. 1885.	2 "
4. May 27, 1884.	June 1891.	7 "
5. Oct. 17, 1885.	" "	5 " 8 mos.
6. May 6, 1886.	July "	5 " 2 "

One over seven years; two over five years; one over four years; one over three years; one over two years. Total, six.

WINTER'S CASES.

DATE OPERATION.	DATE OF REPORT.	EXEMPTION.
1. March 26, 1886.	June 1891.	5 yrs. 3 mos.
2. May 24, 1889.	May "	2 "
3. June 14, "	June 22, "	2 "
4. July 6, "	July 4, "	2 "
5. " 17, "	" 30, "	2 "
6. " 24, "	" 7, "	2 "

One over five years; five over two years. Total, six.

KRAMER'S CASES.

DATE OPERATION.	DATE OF REPORT.	EXEMPTION.
Dec. 6, 1888.	Aug. 4, 1891.	2 yrs. 8 mos.
Jany. 18, 1889.	July 4, "	2 " 6 "
March 23, "	" 7, "	2 " 4 " 4 over 2 years.
Apl. 4, "	June 28, "	2 " 2 "

Cohn, one case 1887; recurred 1890; two years exempt.

Bencheiser, one case; four years; no recurrence.

Reichel, one case; five years, no recurrence. In all sixty-three cases

[25] Recurrence observed in August.

In summing up these tables we will observe that

1	case out of 235	operated	upon had	no recurrence for	over 8 years.
1	"	"	"	7	"
1	"	"	"	6	"
7	"	"	"	5	"
17	"	"	"	4	"
15	"	"	"	3	"
19	"	"	"	2	"
2	"	"	"	1	"

So, these 63 patients, being but 27 per cent. of the whole, had an average exemption from relapse of three years and four months for each, while nothing whatever is said as to the fate of 172 or 73 per cent. of the entire number operated upon. If we take into account the probable history of these 172 less fortunate sufferers, and I do not see why we should not, and allow one year for each, we have an aggregate of 381 years exemption for 235 patients, or 1 year, 7 months and thirteen days for each.

Olshausen reported at the International Congress in Berlin, in 1890, 163 cases of hysterectomy for cancer at the University Woman's Klinik from May 1, 1887 to May 1, 1890—twenty-two or 13.5 per cent. died. After two years forty were living, but of the entire number who escaped death in the operation (151) only nineteen of them were free from recurrence.

Of his earlier operations, thirty-nine in number, from April, 1881 to April 1887, six were then living and free from relapse. One after three-and-a-half years; one after four years; one after seven years; two after eight years, and one after nine years. In exhibiting the uterus taken from the last named patient he said, "this is the longest time that has elapsed after operation, without recurrence."

Thus in the space of three years no less than one hundred and sixty-three hysterectomies were performed in one institution, and at the expiration of two years there were but forty living, nineteen without recurrence and twenty-one doubtless much worse than if they had never run the gauntlet of hysterectomy.

Exhibits like these, and statistics are full of them, cannot be but discouraging to our advanced and exclusively modern gynæcologists. If like results were generally known to attend the treatment, medical or surgical, of any other malady, it were better that its victims should bear the ills they have, or trust to "the faith cure." In a business point of view it is certainly disheartening to the advocates of home industry in this particular line, and it behooves our radical advance-guards to look to their coveted laurels. Up to now, their best efforts have been put forward in scouring the country for material wherewith to break the record, and in some

individual instances with considerable promise of success. Failure, however, if it should come, would be most disastrous; during their eager pursuit for notoriety, the whole business might become to say the least unpopular, each hysterectomist might find himself in the position of Shakspeare's swarthy Venetian: his first, second or third series of ten, fifty or one hundred operations, on paper, might spoil on his hands; or, like an off-style article of ladies' head-wear, become such a drug in the market that no amount of professional advertising would enable him to turn his wares to profitable account.

Per contra, Kaltenbach (Halle) tested the credulity of his audience at the same time by stating that he had but two deaths in eighty operations. A phenomenal experience truly, but an equally delusive and dangerous precedent, as the following tables will show.

Name.	Number Operations.	Primary Deaths.	Per Cent.
1. Olshausen	163	22	13.5
2. Kaltenbach	80	2	2.5
3. Leopold	80	4	5.
4. Martin [26]	134	22	16.5
5. Hoffmeir	42	4	9.5
6. Fritsch	63	7	11.
7. Schroeder	60	12	20.
8. Gusserow	67	7	10.5
9. Schauta	55	5	9.
10. Zayaitzki	65	19	29.
11. Bouilly	51	16	31.
12. Terrier	34	8	23.5
13. P. Ségond	33	7	21.
14. Sanger	17	2	11.8
	944	137	14.5

BRITISH OPERATIONS.

Name	Operations.	Primary Deaths.
1. Sinclair	42	5
2. Purcell	11	4
3. Braithwaite	11	1
4. Murphy	1	1
5. Beaufoot	2	1
6. Cullingworth	4	1
7. Lawrabon	2	1
8. Nesbitt	1	1
	74	15, over 20 per cent.

[26] Quoted by Ott, *Annals de Tocologie*, Paris, 1889, xxxii, pp. 241–271, and 327–334.

AMERICAN OPERATIONS.

NAME.	OPERATIONS.	DEATHS.
Price	53	3
Boldt	36	3
Cushing	38	4
Coe and Hunter	19	5
Byford, Martin and Nelson	20	1
Krug	7	1
Reamy	12	2
Wylie	20	1
Eastman	13	3
Reed	11	3
Polk	16	4
Montgomery	6	1
Winning	4	3
16 operators.	255	34, over 13 per cent.

	OPERATORS.	OPERATIONS.	DEATHS.	PER CENT.
European (continental).	14	944	137	14.5
British	8	74	15	20.
United States	16	255	34	13.
Total	38	1273	186	14.6

Further comment on these statistics, even did time permit, would seem to be uncalled for. They speak for themselves, and, in my opinion, so emphatically, that "they who run may read."

The lessons which they teach are plain and of vital importance, and the following *conclusions*, in part essentially those arrived at by Dr. Jackson five years ago, would seem to me to be fully substantiated by the array of glaring though distorted clinical facts here presented.

1. *The ambiguous manner in which the statistical tables of vaginal hysterectomy have been constructed, is so misleading and, in some instances so suggestive of erroneous inferences as to render their compilers open to a charge of SUPPRESSIO VERI or SUGGESTIO FALSI.*

2. *Any operation known to be attended or followed by an average primary mortality of over fourteen per cent. in the hands of the most experienced surgeons, is a grave and a dangerous one, and demands for its justification a large percentage of PERMANENT CURES.*

3. *The frequency and rapidity with which recurrence takes place after vaginal hysterectomy for cancer, even when the disease has ap-*

peared to be limited and circumscribed, prove conclusively that it can lay no just claim to this essential feature.

4. *As the average period of life in cancer of the uterus, when not operated upon, is not less than two years but often more, suffering has not been lessened but aggravated, and life has not been prolonged but shortened, in the vast majority of all cases thus far subjected to vaginal hysterectomy.*

5. *As in twenty-eight cases of vaginal hysterectomy for cancer of the fundus at the Berlin Klinik, no less than seven died from recurrence within twelve months, the regional grounds on which some have conconceded to this operation even a limited field are inconsistent with facts, and therefore not tenable.*

6. *As the operation is, in many respects, more dangerous than the disease for which it is undertaken, and, as the majority of all patients afflicted with uterine cancer would live longer without than with it, it is not a safe nor a useful operation and as such is unjustifiable.*

7. *On several occasions during the past twenty years, and more particularly in a paper read before this society three years ago, ample and convincing proof, clinical and statistical, was presented, as to the claims and unique characteristics of the electric cautery in the treatment of uterine cancer, and further observation has been more than confirmatory of opinions then advanced.*

8. *Amputation of a cancerous cervix by the cautery knife is free from danger, a safeguard against all infection, traumatic or septic, and, what is of still greater importance, it is destructive to latent cancer-cell proliferation in tissues far beyond the line of incision; hence, much more is comprised in the operation than the mere removal of a part or parts more actively involved in the work of destruction.*

9. *Any method of operating for which advantages so vital and so far-reaching can be claimed and established, and which thus distinguish it from all others, renders its adoption on the part of those who undertake to operate for cancer of the uterus no less than a MORAL OBLIGATION.*

I have often been asked to explain what at first thought appeared to be a transparent incongruity, namely, why better results should follow or be claimed for amputation of a cancerous cervix by galvano cautery, than for the same operation by other means, or, above all, the extirpation of the entire uterus by any of the methods ordinarily resorted to. At first I could do little more than to point to clinical facts and venture to surmise that coincident with either of the latter surgical procedures, there might take place a traumatic infection in parametric tissues, which, though apparently healthy, were, in all probability, already predisposed

in some especial manner to pathological changes. Increased experience in the treatment of uterine cancer by galvano cautery renders it more than probable that this will be found to be the only rational hypothesis, and one which is strongly fortified by clinical observation.

Moreover, I am of the opinion that in the parametric tissue of many cancerous uteri, and much beyond what might seem to be the limit of disease, there exist some morbid cell changes due to faulty nutrition, or cancer germs, but, in so undeveloped a state as to be inappreciable even by the aid of the most powerful microscope. Under such circumstances there is surely nothing unreasonable in surmising that cell proliferation, hitherto slow, or almost dormant, would be hastened, and that formative processes, so responsive to any kind of irritation, would be roused into active life through the traumatic stimulus of an operation, and the exposure of more or less extensive raw surfaces. On the other hand, in the progress of an amputation by cautery, and where the heated knife is so long, and repeatedly applied, (for such operations must be slow) the effects of the heat on outlying structures may be imagined by the shriveled and comparatively small size of what had been, before operation, a voluminous cervix. In no other manner do I think it possible to explain certain phenomena following these operations by galvano-cautery, e. g., (1) absence of fever and almost all pain, pelvic or peritoneal; (2) the almost universal immunity of the scar tissue after cauterization from secondary attack in the event of recurrence of the disease, and (3) in the case of relapse, the long respite obtained from reappearance of the disease in remote parts, even in the more unpromising cases of undoubted circum-uterine infiltration.

In conclusion, I feel that I owe you an apology for trespassing to so unusual a degree on your kindness and patience. My aim has been to arrive at some reasonable and truthful interpretation of the statistics of hysterectomy, and at the same time to urge the claims of a method of treating uterine cancer, which, I believe, has not received that consideration to which it has for many years been proved to be entitled.

It is a matter for regret, and a source of surprise to many, that while European authorities have not failed to chronicle from time to time certain facts connected with the treatment of uterine cancer by galvano-cautery, as observed and duly recorded in this country, some of our American authors, unmindful of their obligations, have assumed the responsibility of withholding from their readers almost everything of consequence connected with the subject. The caustic remarks of a medical friend in noticing this unaccountable omission, though severe, can hardly be said to be much out of place. He writes me as follows: "*Any author who wilfully sup-*

presses some of the most important facts in current literature, and bearing on a subject which he presumes to discuss, displays a reckless disregard for his own reputation, as well as for the opinions and rights of others.

"The musty records of Braun and Schroeder may savor of ancient history, but if leavened with a passing reference to the more modern views of Reamy and Baker, just for appearance sake, the subject will have been dealt with in a sufficiently exhaustive manner to meet all reasonable demands of the American reader and the American market. 'O Tempora! O Mores!'"

But, my friends, it is, I regret to say, the besetting passion of the time in society discussions, scientific papers, and even in more or less but usually more pretentious works, to so trade on the opinions of foreign writers, that it would seem as if gynæcology had forfeited its right to "a local habitation and a name," in this great republic of the west. Indeed, at the present day, it would seem as if nothing in the way of reckless surgery could be too impracticable or too absurd for commendation and imitation when permissible, provided it emanate from some "professor" however obscure, if only hailing from some university town in Europe.

Is it not, I submit, quite time that this unpardonable sycophancy, this pitiable servility, should cease to offend the intelligence, common sense, and patience of the bulk of our profession? Aping erudition is surely no proof of merit. There was a time, and it is not so very long ago, when it was not uncommon to hear America referred to as the birthplace of advanced and progressive gynæcology, and when the gifted and lamented Sims and our distinguished Fellow, Emmet, were demonstrating to the world the curability of ailments, which, until their time, were deemed beyond the resources of art. Nevertheless, at that very epoch, and as if oblivious to all this, articles on the accidents of parturition continued to be written, and text-books published for a considerable time, without note or comment on matters with which all here had been long familiar. As a noteworthy example, about twenty years ago the late Professor Charles Budd amused some members of the Obstetrical Society of New York, by stating as part of his experience on visiting a large metropolitan hospital in Europe the previous season, that he saw the surgeon on duty displaying his skill before a class by rubbing the edges of a vesico-vaginal fistula with a stick of nitrate of silver. At this very time we were probably extolling and practicing Freund's operation, or Nussbaum's method of exploring the abdominal viscera by a hand and arm forced through the rectum. Indeed, nearly ten years elapsed before the

most important of the beneficent fruits of Sims' genius could be said to be appreciated, and even now some of our European idols, in return for our worship, would fain belittle, and through misrepresentation of its author's explicit views and directions, condemn one of the most valuable operations in the whole field of minor gynæcology. I refer to Emmet's operation for laceration of the cervix.

Let it not be imagined that this outspoken reference to a delicate subject springs from any illiberal spirit. Far be it from me to say ought that might detract from the well-deserved fame of illustrious European gynæcologists, to whose labors and original investigations we owe much, but, while admiring the verdure of far off fields let us cease to act as if our own were a barren waste. Medical science in all its departments must necessarily be cosmopolitan in the widest sense. Hence, on matters professional, we should be actuated by no selfish consideration, wedded to no hobby, faction, clique or country, swayed by no predilection, and influenced by no prejudice, but sink every inferior motive before the main object, *Principle*. Let truth, honor, candor and liberality be the only stepping stones to the genuine dignity and nobility of our calling.

Tros Tyriosve mihi nullo discrimine agetur.

RULES TO BE OBSERVED IN PERFORMING HIGH AMPUTATION AND OTHER OPERATIVE MEASURES FOR CANCER OF THE UTERUS BY GALVANO-CAUTERY.

BY JOHN BYRNE, M.D., M.R.C.S.E.

The American Gynæcological Society at its late meeting in Brooklyn, departing from the rule hitherto strictly observed of confining all papers to its volume of transactions, unanimously resolved to authorize and recommend the publication of the President's address in one of the medical journals.

To this resolution was also added the request that the president would include or add thereto some brief description of his method of performing high amputation of the cervix, or otherwise treating uterine cancer.

In compliance with this request, therefore, I have prepared the following:

NOTE.—The illustrations of this Article are, by permission, from advance sheets of the "International System of Electro-Therapeutics," by Horatio R. Bigelow, M.D. Figs. 4 and 8 are from photographs by H. V. Byrne, M.D.

It is well known to all who have had much experience with uterine cancer that in a very large percentage of the cases met with, whether in private or hospital practice, the disease is found to have already progressed so far that palliative results or a brief respite from suffering and death is all that can be hoped for from any treatment. In such cases, as for example when the entire cervix has been destroyed and the corpus uteri as well as the parametric tissues are found to be involved, my course has been as follows: First, to remove all softened and broken-down tissue by the free use of a *sharp* curette, and having sponged the cavity repeatedly with a mixture of one part of commercial acetic acid, three parts of glycerine, and carbolic acid sufficient to represent eight per cent. of the whole, I then pack the cavity with absorbent cotton and allow it to remain for a few minutes or longer as the case may be. On removing this, if all bleeding is found to have ceased, and the cavity fairly dry, cauterization may be proceeded with. If, however, oozing of blood to any extent should still continue, it will be best to pass into the cavity a properly rolled tampon saturated with the above styptic, and allowed to remain for forty-eight hours before the application of the cautery.

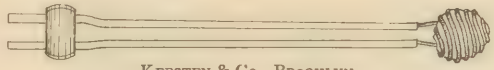

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FIG. 1.

Cauterization in all such cases should be conducted in the following manner:

The diseased organ should be exposed to view and the vagina protected by a Sims' speculum, and an anterior and two lateral retractors, and it may be necessary to seize the edges of the excavation by one or more volsella. Before introducing the cautery electrode a wad of absorbent cotton is to be passed into the cavity, held for a moment, and immediately, on being withdrawn, the dome-shaped instrument, Fig. 1, brought to a cherry-red heat, is to be rapidly and repeatedly passed over *the bottom* of the cavity mainly. The latter is then to be again dried by wads of absorbent cotton held in dressing forceps, and cauterization resumed as in the first instance. This process is to be repeated over and over again, until the deeper parts of the cavity have become dry and charred, when the sides are to be treated in precisely the same manner, and *roasted* to the same crisp condition. The seat of operation will now present the appearance of a perfectly black and *dry* cavity. All ragged and overlapping edges are next to be trimmed off by the cautery knife, a

firmly rolled tampon of suitable size with thread attached, and saturated with the above styptic compound, is now to be placed in the cavity, and, finally, a supporting vaginal tampon is to be applied and the patient removed to bed. The *vaginal* tampon may be removed on the following day, but the other had better be allowed to remain for forty-eight hours or longer. The subsequent treatment will consist of vaginal douches twice daily of carbolized water.

HIGH AMPUTATION.

In conditions admitting of high amputation, the following is the method usually resorted to: The uterus is to be exposed and the vaginal walls protected in the manner already described. The diverging volsellum, Fig. 2, being passed well into the cervical canal,

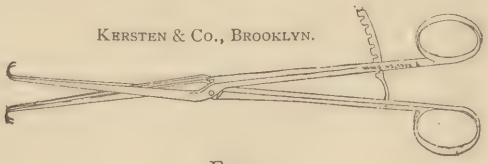


FIG. 2.

should now be expanded to a proper degree and locked, so as to afford complete control of the uterus during the entire operation.

By alternate traction and upward pressure of the uterus, an accurate idea may now be obtained as to the proper point to begin the circular incision, so as to avoid injuring the bladder or opening into the *cul-de-sac* of Douglass. As to the latter, however, should it be found that the disease has involved the retro-uterine tissues, and that its excision or destruction by the cautery cannot be effected without opening into the peritoneal cavity, there need be no hesitation in doing so, as I have never known any harm to come from it whether done accidentally or by design. Should it be evident at the outset that the operation, in order to be thorough, must include a portion of the *cul-de-sac*, it will be better to make the line of incision anterior to this, until the cervix has been removed, and leave the excision of the retro-uterine parts *by the cautery knife*, to be the final proceeding. Under these circumstances all that will be needed will be an antiseptic tampon properly applied.

FIG. 3.

In proceeding to make the circular incision the cautery knife, Fig. 3, slightly curved *and cold*, should be applied close up to the

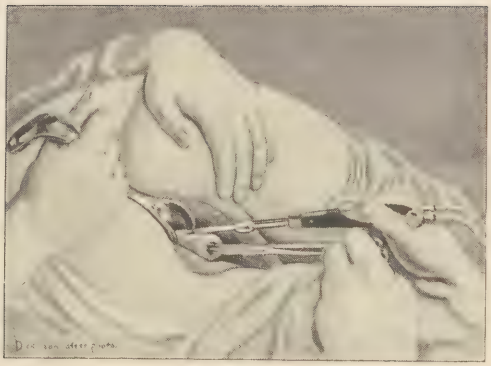


FIG. 4.

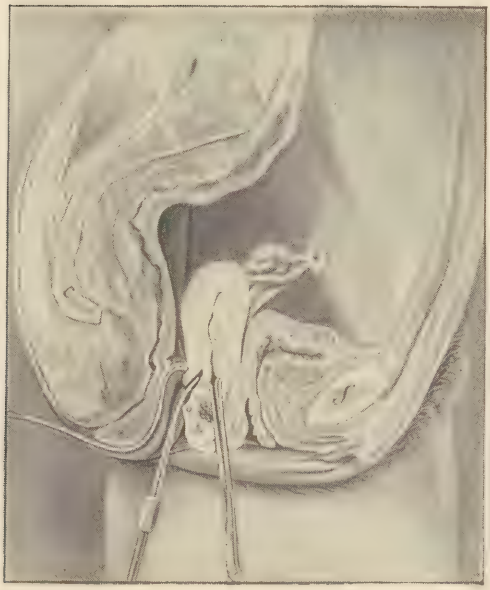


FIG. 5.

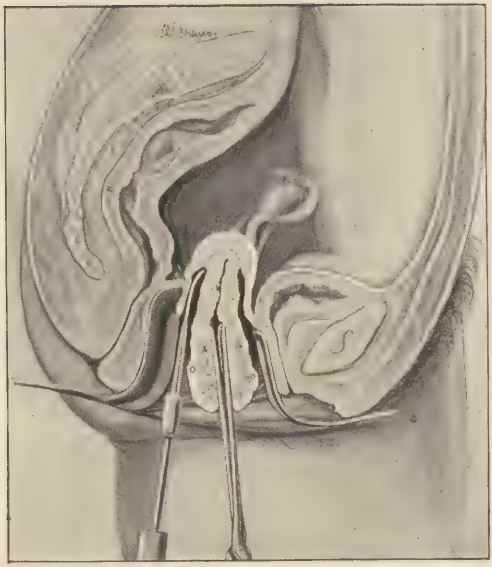


Fig 6.

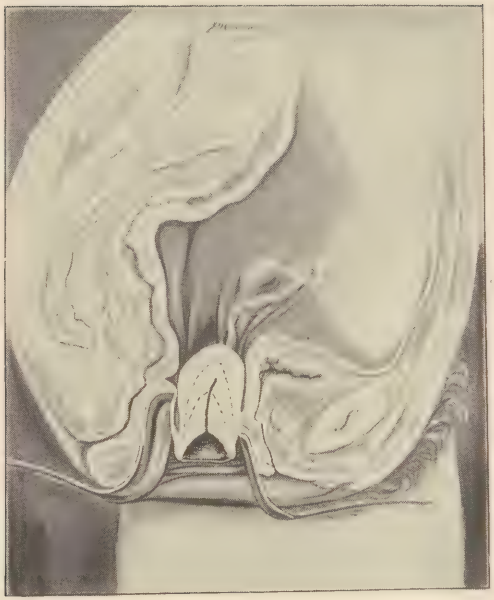


Fig. 7.

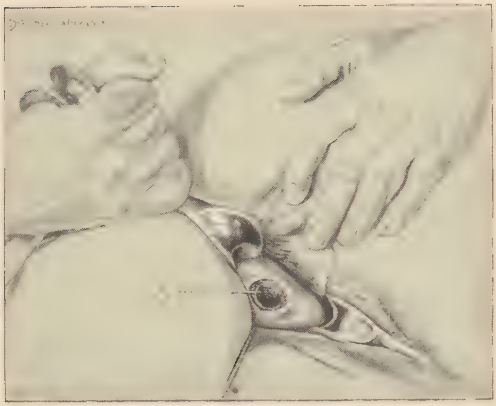


Fig. 8.

vaginal junction, and from the moment that the current is turned on, should be kept in contact with the parts being incised. Fig. 4. Before removing the electrode for any purpose such as change of position, or altering the curve of the knife, the current should first be stopped and the instrument again placed in position while *cool* before resuming incision. In other words, if *the knife, though heated only to a dull red, be applied to parts at all vascular, hæmorrhage more or less will certainly follow; whereas, the cool platinum blade being already in contact with moisture as the current is being transformed into heat, vessels are shrunken or closed even before they are severed.*

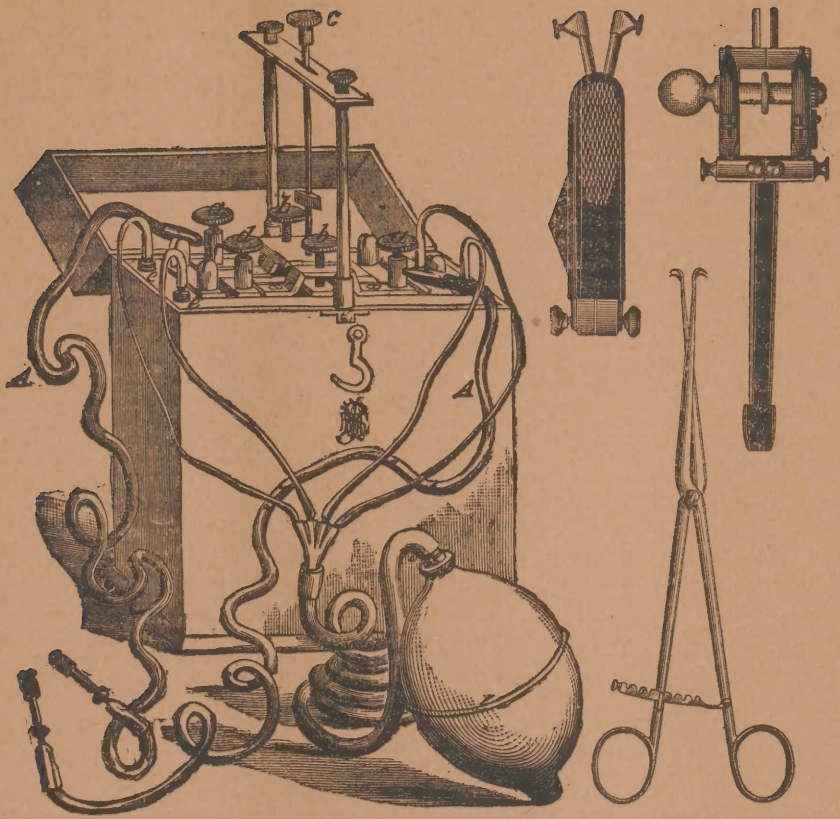
This is a very important point and should never be lost sight of in all cautery operations.

The circular incision having being made to the depth say of a quarter of an inch, it will now be observed that by increased traction the uterus may be drawn much farther downward, and by directing the knife upward and inward the amputation may be carried to any desired extent (Figs. 5 and 6). In cases calling for amputation above the os internum, it will be better to excise and remove the cervix first, then, by dilating the upper canal sufficient to admit the diverging volsellum, once more proceed as in the first instance, taking care, however, to keep within bounds (Figs. 7 and 8). It will be found that the cupped stump can now be drawn down and made to project as a more or less convex body.

In all cases the dome-shaped electrode (Fig. 1) should be passed over the entire cavity repeatedly so as to render the cauterization still more complete.

It is important to add that, in carrying the knife toward the *sides* of the cervix, circular and other arterial branches are apt to be encountered, and hence, in this locality particularly, a high degree of heat in the platinum blade is to be carefully avoided. As an additional security against hæmorrhage, the convexity of the knife should be pressed against the external surface of each particular section cut, so as to close vessels more effectually.

It is well to state that the metallic parts of the electrode *for the distance of about two inches should be covered with a strip of thin flannel, so that the vagina may be protected from injury through the reflected heat.*



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